

Preadmission Screening Resident Review Training Handout

OBRA 1987 amended 1990

Requirements of PASRR

- PASRR screening consists of 2 parts
 - Level I
 - Level II
- PASRR requirements have not changed.
- A need to refocus emphasis on process and forms has been identified.

HISTORY OF PASRR

- For a state to have its Medicaid plan approved by the Centers for Medicare and Medicaid Services (CMS), it must maintain a PASRR program that complies with the relevant federal laws and regulations.

HISTORY OF PASRR

- Rules for Completion
- Information Used
- Timelines

Are clearly identified in CFR 483.102 – 483.136

HISTORY OF PASRR

- The PASRR program was enacted out of concern resulting from initial de-institutional efforts, and that many people with
 - Mental Illness –
 - » Major Mental Illness (MMI)
 - » Significant Mental Illness (SMI)
 - Intellectual Disability (ID)
- Are appropriately placed in nursing facilities
- Will receive specialized services if needed

EVERYONE who applies for admission to a nursing facility (NF) must be “screened” for evidence of major mental illness (MMI/MI) and/or intellectual disability (ID), developmental disabilities, or related conditions

PASRR screening must occur
regardless of payment source.

The intent is to ensure that all NF applicants are

- Thoroughly evaluated
- Placed in a NF **only** when appropriate
- Receive all necessary services while there

PASRR is concerned with:

- Patient's rights
- Quality of care
- Appropriate care
- Quality of Life

The 1999 Olmstead US Supreme Court case requires that we all be concerned about the care provided in the least restrictive setting appropriate to the persons needs.

Least Restrictive

Most Appropriate

The NF must **not** admit an applicant who has MI and/or ID unless the appropriate state agency has determined whether:

- the individual needs the level of services that a NF provides (meets NF level of care)
- Whether the individuals that need NF services also need high intensity “*specialized services*”

MI/SMI Definitions

The federal definition of MI for PASRR is best understood in terms of the four “D’s”

- A **diagnosis** or suspicion of a major mental illness such as schizophrenia, bipolar disorder, major depression, or an anxiety disorder such as OCD.

MI/SMI Definitions

- An *absence* of **dementia**. If dementia is also present (co-morbid with) MI, it cannot be the primary diagnosis. The individual's MI must be more serious than their dementia.
- A well defined **duration**. To be relevant, intensive psychiatric treatment for MI must have taken place within the last two (2) years.

MI/SMI Definitions

- A particular level of **disability**. The individual's MI must have resulted in functional limitations in major life activities within the past 3 to 6 months. The individual need not have received treatment. It is the severity and recent timeframe of impairment that matters, not whether the individual was hospitalized or even saw a mental health professional.

ID Definitions

The federal definition of ID for PASRR was published in 1983 by the American Association on Intellectual and Developmental Disabilities (AAIDD), formerly called the American Association on Mental Retardation (AAMR).

ID Definitions

- Requires an IQ score of less than 70, as measured by a standardized, reliable test of intellectual functioning.
- Encompasses a wide range of conditions and levels of impairment
- Must have concurrent impairments in adaptive functioning
- Must manifest before the age of 22
- Must be likely to persist throughout a person's life.

ID Related Conditions Definition

PASRR is intended to identify and evaluate individuals with “related conditions” including autism, cerebral palsy, Down Syndrome, fetal alcohol syndrome, muscular dystrophy, seizure disorder, and traumatic brain injury.

ID Related Conditions Definition

- Conditions that are not a form of intellectual disability
- Produces similar functional impairments
- Requires similar treatment or services
- Must manifest before the age of 22
- Must be expected to continue indefinitely
- Must result in substantial functional limitations in 3 or more major life activities

Major Life Activities

- Self Care
- Understanding and use of language
- Learning
- Mobility
- Self Direction
- Capacity for independent living

Level I - HW 0087

First Step of PASRR Process

- Can be completed by physician or physician extender (if monitored by physician) or a hospital discharge planner who is an RN or Licensed Social Worker
- Identifies who ***may*** have a serious MI condition and/or ID

Level I Hospital Completion

Hospital staff may experience disincentive to trigger a Level II due to pressure to discharge

- Significant MI and ID diagnosis will be present the day the person is admitted to the hospital
- Discharge Planning can start on day one if it is suspected the person may have a positive Level I, and may need NF admission

Level I Hospital Completion

- Hospital staff has easy access to the individual and/or family
- A new Level I (HW 0087) has been developed to facilitate gathering of factual information

The HW 0087 must be completed in its entirety including all demographics and answering of all questions.

Level 1 Pre-Admission Screening and Resident Review (PASRR)

First Name: _____ Middle Initial: _____ Last Name: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
Social Security #: _____ - _____ - _____ MID: _____ Gender Male Female Date of Birth: ____ / ____ / ____
Current Location: Medical Facility Psychiatric Facility Nursing Facility Community/Home Other _____
Proposed NF Admission Date: ____ / ____ / ____ Receiving Nursing Facility: _____
Receiving Nursing Facility Address: _____ City: _____ State: _____ Zip: _____
Legal Representative _____ Phone _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

 No

Suspected: One or more of the following diagnosis is suspected (check all that apply)

Yes: (check all that apply)

Schizophrenia Paranoid Disorder

Schizoaffective Disorder

Major Depression

Psychotic/Delusional Disorder

Bipolar Disorder (manic depression)

2. Does the individual have any of the following mental disorders?

 No

Suspected: One or more of the following diagnoses is suspected (check all that apply)

Yes: (check all that apply)

Personality Disorder

Anxiety Disorder

Panic Disorder

Depression (mild or situational)

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do NOT list dementia here)

 No

Yes (if yes, enter the diagnosis(es) below:)

Diagnosis 1: _____

Diagnosis 2: _____

Section II: SYMPTOMS

4. Interpersonal – Currently or within the **past 6 months**, has the Individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]? No Yes

- Serious difficulty interacting with others
- Altercations, evictions, or unstable employment
- Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

5. Concentration/Task related symptoms – Currently or within the **past 6 months**, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]? No Yes

- Serious difficulty completing tasks that she/he should be capable of completing
- Required assistance with tasks for which she/he should be capable of completing
- Substantial errors with tasks in which she/he completes

Adaptation to change – Currently or within the **past 6 months**, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? No Yes

6. Self Injurious or self mutilation
 Suicidal Talk/Ideations
 History of suicide attempt or gestures
 Physical violence
 Physical threats (with potential for harm)

7. Severe appetite disturbance
 Hallucinations or delusions
 Serious loss of interest in things
 Excessive tearfulness
 Excessive irritability
 Physical threats (no potential for harm)

8. Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms:

Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the **past 2 years**, has the individual received any of the following mental health services? No

Yes (the individual has received the following service(s))

Inpatient psychiatric hospitalizations (if yes, provide date: _____)

Partial hospitalization/day treatment (if yes, provide date: _____)

Residential treatment (if yes, provide date: _____)

Other: _____ (if yes provide date: _____)

10. Currently or within the **past 2 years**, has the individual experienced significant life disruption because of mental health symptoms? No Yes (check all that apply)

Legal intervention due to mental health symptoms (date: _____)

Housing change because of mental illness date: _____

Suicide attempt or ideation (date(s): _____)

Other (date: _____)

11. Has the individual had a recent psychiatric/behavioral evaluation? No Yes (date: _____)

Section IV: DEMENTIA

12. Does the individual have a *PRIMARY* diagnosis of dementia or Alzheimer's disease?
 No (proceed to 15) Yes (proceed to 13)

13. If yes to #12, attach corroborative testing or other information available to verify the Presence or progression of the dementia? No Yes (check all that apply)
 Dementia work up Mental Status Exam Other (specify)

14. If yes to 12, list currently prescribed antidepressant or antipsychotic medications listed on the Beer's List.

Medication	Dosage MG/Day	Refer to Beer's List
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes

Section V: PSYCHOTROPIC MEDICATIONS

15. Has the individual been prescribed psychoactive (mental health) medications other than those listed in question 14? No Yes

**Do not list medications if used for a medical diagnosis or medications used for the treatment of behaviors r/t a medical condition i.e. Dementia.*

List any medications used that resulted in an adverse reaction.

Medication	Dosage MG/Day	Diagnosis	Started	Ended

Section VI: INTELLECTUAL DISABILITIES & DEVELOPMENTAL DISABILITIES

16. Does the individual have a diagnosis of intellectual disability (ID) or developmental disability (DD) or related condition? No Yes

Related Condition diagnosis which impairs intellectual functioning or adaptive behavior:

Down Syndrome Cerebral Palsy Autism Epilepsy
 Fetal Alcohol Syndrome Closed Head Injury Other: _____

Substantial functional limitations in 3 or more of the following secondary to Related Condition

Mobility Learning Capability of independent living
 Understanding use of language Self Care Self Direction

Did the condition manifest prior to age 22? No Yes

17. Does the individual have any history of ID or DD?

No Yes

18. Is there presenting evidence of a cognitive or behavioral impairment prior to age 22 or suspicion of ID condition that occurred prior to age 22? No Yes

19. Has the individual ever received services from an agency that serves people affected by ID/DD?

No Yes Agency: _____

Signature of Physician or Hospital Discharge Planner (RN or LSW)

Phone

Date

If not completed by Physician or Discharge Planner, this form must be completed by **both** of the following:

For Section I-V only:

For Section VI only:

Signature of QMHP

Signature of QJDP

Qualification/Job Title

Date

Qualification/Job Title

Date

Forward to Bureau of Long Term Care (BLTC) if ANY of the following are marked Yes:

1 6 7 9 10 14 15 16 17 18 19 AND complete notification below

Attach the following: History & Physical Updating Documentation Level of Care Certification

Discharge Orders/Summary

Functional/ADL Assessment

Notification of MH/DD review:

_____ has been identified with possible indicators of mental illness and/or mental retardation/developmental disabilities and requires further screening.

This is mandated by Omnibus Budget Reconciliation Act of 1987, per Section 1919 (b)(3)(F).

You may be contacted by a representative of the Department of Health and Welfare concerning further screening and results of the screening when it is completed.

Print Individual Name _____

Signature of Individual: _____

Date / /

Signature of Legal representative/Guardian _____

Date / /

Additional Documentation

- Mini mental exam
 - Assessment to verify the presence of Alzheimer's/Dementia as a primary diagnosis
- Beer's List
 - Identify antidepressant/antipsychotic medications used for treatment of behaviors associated with Alzheimer's/Dementia or other Organic conditions
- Geriatric Depression Scale
 - Screening tool used to identify the presence of depression in the elderly

30 Day Hospital Exemption

- HW 0087/Level I is positive for MI/ID diagnosis
- The physician writes an order that the person is being discharged to a NF from a hospital for rehab and the stay is less than 30 days.
- Level I needs to be forwarded to Medicaid Bureau of Long Term Care (BLTC) to make determination

Level II- HW 0090

PASRR process continues

- Completed by BLTC and the MH/DD authorities using information from HW0087 and required documentation
- 2 decisions are made
 - Nursing Facility level of care
 - Need for specialized services or services of lesser intensity

HW 0090

**LEVEL II PASRR SCREENING
FOR NURSING FACILITY PLACEMENT**

Name: _____ MID: _____ SSN: _____
NF: _____ Admit Date: ____/____/____

Part 1

THE FOLLOWING DATA MUST BE USED TO MAKE A DETERMINATION:

Date:

- _____ Physician's Medical Evaluation and Physical Examination
- _____ Physician's Plan of Care, including prognosis
- _____ Physician's Certification of Level of Care
- _____ Psychiatric/Psychological Evaluations, if available
- _____ Social Information
- _____ Level 1 Preadmission Screen (HW 0087)

- 20. Individual does not meet nursing facility level of care and may not be admitted or continue to reside in a Medicaid certified facility.

Section VII EXEMPTION AND CATEGORICAL DECISIONS

21. EXEMPTIONS ADDITIONAL LEVEL II EVALUATION NOT NEEDED

- a. Nursing Facility Readmission after hospital stay for the purpose of receiving care
- b. Interfacility transfer (Screen complete/current) from one facility to another with or without intervening medical/
Hospital stay
- c. Swing bed
- d. Admission meets criteria for Hospital Exemption

And meets all the following and has a known or suspected MMI or ID/DD Diagnosis:

Admission to NF directly from hospital after receiving acute medical care, and

- Need for NF is required for the condition treated in the hospital
(specify condition): _____, and
- The attending physician has certified prior to NF admissions the individual will require less than 30 calendar days of NF services – and – the individual’s symptoms or behaviors are stable.

Physician Name _____

Physician Phone _____ Fax _____

Additional Comments: _____

**Individuals meeting (d) criteria are exempt from Level II screens for 30 calendar days. The receiving facility must update the Level 1 screen at such time that it appears the individuals stay will exceed 30 days and no later than the 40th calendar day.*

22. CATEGORICAL DETERMINATION

LEVEL II EVALUATION NEEDED IF ADMISSION EXCEEDS CATEGORICAL DETERMINATION LIMIT.
REFER TO MH/DD AUTHORITY FOR DECISION.

Individual meets NF eligibility and does not require specialized services for the time limit specified.

- a. Emergency protective service situation for MI/ID /RC individual needing 7 calendar days NF placement
- b. Delirium precludes the ability to accurately diagnose. A Level II Evaluation is required at such time that the Delirium clears and/or no later than 7 calendar days from admission.
- c. Respite is needed for in-home caregivers to whom the MI/ID /RC individual will return within 30 calendar days

HW 0090

Name:

23. ADVANCED GROUP CATEGORICAL DETERMINATIONS - FURTHER EVALUATION FOR SPECIALIZED SERVICES NEEDED. REFER TO MH/DD AUTHORITY FOR DECISION.

- a. Does the admission meet the criteria for Terminal Illness? Has a known or suspected MMI or ID/DD and Physician has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted (check on in 6 months).
- b. Does the admission meet the criteria for Severity of Illness? (Has a known or suspected MMI or ID/DD and is ventilator dependent or comatose functioning at a brain stem level, or diagnoses such as COPD, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.) (check in 1 year)
- c. Does the admission meet criteria for 120 days Non-Exempt Convalescence?
(*meets all* of the following and has a known or suspected MMI or ID/DD)
 - Admission to NF directly from hospital after receiving acute medical care; and
 - Need for NF is required for the condition treated in the hospital; and
 - Convalescent stay that doesn't meet Hospital Exemption criteria (check in 120 days).
- d. Dual diagnosis of ID/Related conditions and Dementia

Section VIII: OUTCOME

Utilizing information from the HW0087

- 24. Are any of the following numbers checked Yes, or Suspected:
 1 6 7 9 10 14 15 16 17 18 19
- 25. Check if #2 is checked Yes or Suspected and any areas in #4-7 are checked
- 26. If #2 is checked Yes or Suspected for mild or situational depression, and/or mild anxiety, and #15 is checked Yes for medication usage to address those diagnosis(es) then check #32.
- 27. Check if #4 or 5 or (any areas in) #7 are marked Yes and #12 is No
- 28. If #12 is checked Yes and supported by #13 and meds in #14 are within Beer's list guidelines, and #1 and #3 are checked No then check #32.
- 29. If any of questions #24, 25 or 27 are checked and #26 and/or #28 does **NOT** apply: Further evaluation is required. Check #31 and complete guardianship information and forward to MH/DD Authority.
- 30. If any of questions #24, 25 or 27 are checked and #26 and/or #28 **does** apply: No further screening is required, check #32 and proceed to Section IX.
- 31. Individual meets criteria for NF level of care. Further evaluation for specialized services required: Proceed to MH/DD Authority Evaluation**
- 32. Individual meets criteria for NF level of care and NO further evaluation for specialized services required.**

Comments:

HW 0090

Name:

Does the individual have a legal guardian/POA/Informal Decision Maker?

No legal representative

Yes, legal representative information is below:

Representative Name

Street

City

State

Zip

Section IX: MEDICAID SIGNATURE

Print Name

Signature

Region

Phone

Fax:

Date:

/ /

MH/DD AUTHORITY TO COMPLETE THE FOLLOWING:

Check all that apply:

33. Individual has a current diagnosis of severe mental illness per PASRR criteria: _____

34. Individual is intellectually disabled and/or has a related condition: _____

CONCLUSION:

35. Specialized services are not normally needed because of:
Terminal illness Severity of illness 120 day Convalescent ID/RC and Dementia

36. This individual is exempt from a Level II Evaluation

37. This individual requires further individualized evaluation for specialized services
MI-forward all information and the HW0088 form to Independent Evaluator to complete
ID – complete HW0089 form

Comments:

Section X: MH/DD AUTHORITY SIGNATURE

Print Name	_____		Signature	_____
Region	Phone	Fax:	Date:	<input type="text"/>

Appeal Rights

You have the right to appeal 20, 33, and 34 if you do not agree with this decision. You may request a fair hearing. To request a fair hearing, complete information below and send this form to:

Administrative Procedures Section
Idaho Department of Health and Welfare
450 West State Street – 10th Floor
Boise, ID 83720-0036
Fax: (208) 334-6558

You have 28 (twenty eight) days from the date of this notice is mailed to request a fair hearing. Your freedom to make a request for a hearing will not be limited to or interfered with in any way.

You may be represented at the hearing by yourself, an attorney, or any person of your choosing.

Why do you believe this action of the Department was wrong?

Name: _____

Relationship to Participant: _____

Date: _____

Nursing Facility Residents – Status Change

PASSR FACT SHEET

A resident reassessment must be completed when there has been a “significant change” in a nursing facility resident’s mental health condition.

The nursing facility is responsible for identifying these changes and notifying their local BLTC to conduct a resident reassessment.

Nursing Facility Residents – Status Change

A PASRR status change or “significant change of condition” for nursing facility residents means a major decline or improvement in the resident’s status that

- Will not normally resolve itself without further intervention by staff or implementing standard disease – related clinical interventions
- Impacts on more than one area of the resident’s health status
- Requires interdisciplinary review or revision of the care plan, or both

Criteria for PASRR Status Change

- Changes in medication or diagnosis
- New diagnosis of Major Mental Illness
 - Major Depression, Schizophrenia, Schizoaffective, Bipolar, Dysthymia, Cyclothymia, Psychotic DO NOS, Paranoid DO
- A significant increase (double or more) in the dosage of any psychiatric meds used for a mental health condition.

Criteria for a PASRR Status Change

- New signs or symptoms of a mental illness that are not reflected on the most recent PASRR review
 - Medical causes such as UTI's, abnormal labs or med reactions should be ruled out first.
- Initial prescription of psychiatric medication for a mental health condition.
 - Any antidepressant for depressive symptoms or any depression diagnosis
 - Any antipsychotic for psychosis – above dosages on the Beer's List for use with dementias.

Criteria that **DO** NOT indicate a PASRR Status Change:

- New diagnosis of anxiety or personality disorder
- New diagnosis of situational depression
- Dementia **with** ...diagnoses
 - Dementia with depression
 - Dementia with agitation, etc.
- Psychiatric medications used for medical condition
 - Elavil for neuropathy
 - Depakote for Seizure D/O, etc.

Criteria that **DO** NOT indicate a PASRR Status Change:

- Medications within the Beer's List limits – **including** antidepressants for insomnia
- Medication increases less than doubling the dosage
- Medication changes within category
 - Changing from one antidepressant to another
- Signs or symptoms of a mental illness already identified in a PASRR review.

BLTC Regional Contacts

Region 1	Region 2
Jean O'Keefe 208-769-1567 x8812 Region 1 Fax 208-666-6856	Lisa Deyoe 208-799-4434 Region 2 Fax 208-799-5167
Region 3	Region 4
Katie Sierra 208-455-7123 Fax 208-454-7625	Marlena Hoffman 208-334-0948 Fax 208-334-0953
Region 5	Region 6
Sue Harvey 208-732-1483 Fax 208-736-2116	Rick Bigler 208-239-6264 Fax 208-239-6269
Region 7	
Michelle Finck 208-528-5753 Fax 208-528-5756	

PASRR Technical Assistance Center PTAC

<http://www.pasrrassist.org/>